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NCA

OFFICE OF INTEGRATION NEWSLETTER

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in·te·gra·tion | in-ti-**grey**-sh*uh* n |

the combining and coordinating of separate parts or elements into a unified whole

COL Patricia Horoho- Walter Reed Health Care System's New Commander

As the first nurse and the first woman to be appointed as the Walter Reed Health Care System's Commander, COL Patricia Horoho assumed command on Thursday, May 24th on the front lawn of the Walter Reed campus in a traditional Army change of command ceremony.

In front of a Tri-Service audience, the new Commander understanding the prodigious and complex challenges that currently face Walter Reed committed to overcoming these challenges through teamwork. "We must be a cohesive team. Cohesion demands individual performance, collective efforts, and a determined commitment to achieve excellence", Horoho said.

In closing her speech, the new WRHCS Commander invited the Walter Reed family to shape its destiny with her. "Join me as we move forward informed by the past, unafraid of the future, and certain that we are America's first team!" Horoho said. ■

Photo: Bernard Little/WRAMC
COL Patricia D. Horoho

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LETTER FROM THE EDITOR




Dear Readers,

This month we celebrated Memorial Day. As many of you did, I feasted on bar-b-cued chicken wings, baked beans, shrimp pasta, and deviled eggs. As I was eating, I paused when a tribute to our fallen soldiers came on network television.

Before the hour long special ended, my eyes filled with tears and my heart filled with pride. During that memorial homage, I was reminded that I am part of the family that serves as the leading health system in military medicine that supports those men and women.

Memorial Day for so many people has become "just another day off." As I did on Memorial Day, its easy for us to get "caught up" in that attitude and lose sight of the monumental importance of the impact the roads we're paving for the future ahead have.

In this month's issue we celebrate these historic times and the impact integration will have on those we serve. We honor the men and women who courageously risk their lives to secure our home land and honor as well their family members who support them on the home front.

Words From Our Flags

By: Maj. Gen Eric B. Schoomaker, CG of WRAMC and NARMC
and Rear Adm. Adam M. Robinson, Jr., CO of NNMC

In August 2005, the military medical flag leaders in the National Capitol Area (NCA) issued a shared vision of integration between National Naval Medical Center (NNMC) and Walter Reed Army Medical Center (WRAMC)

"We envision one unified National Capital Area (NCA) military health care system. Jointly staffed inpatient campuses at Walter Reed National Military Medical Center at Bethesda (North) and Fort Belvoir (South) will provide high quality, efficient and convenient care for our beneficiaries. The Walter Reed National Military Medical Center (WRNMMC) will serve as a world class academic medical center focused on highest quality tertiary care, graduate medical education, and clinical research while serving as a worldwide military referral center. The Ft. Belvoir community hospital will be the major satellite teaching hospital. Both campuses will be sized to provide health care at the closest facility to the beneficiary whenever clinically appropriate".

The last twenty months have presented many integration challenges to NNMC and WRAMC but the shared vision holds strong. The principles of the shared vision have guided the staffs of these Medcens through the Program for Design (PFD) process in 2006 and provided the needed framework for the architects during the design plans ("charrettes") conducted in February and March 2007 for the new community hospital at Fort Belvoir and the new WRNMMC, respectively. During the same period of time, we've also seen changes in our leadership but we continue to embrace and promote the principles outlined in the original shared vision.

WRNMMC will be a world class academic facility focused on the highest quality care, graduate health professional education and clinical research. Given that it is critical to the entire integrated NCA healthcare system, Medical Center (MEDCEN) integration remains a major focus for both of us and our leadership teams. Successful MEDCEN integration will contribute immeasurably to an integrated health care system in the NCA that is unsurpassed in quality and relevancy to our valued beneficiaries.

The integration of the MEDCENs will not occur in a vacuum. A parallel process of integration with critical links must occur between the MEDCENs and the NCA for us to attain our goal of an integrated health care system. Health care services, Readiness, Health Profession Education) and research are four very vital concepts that link the integration of the MEDCENs with the NCA. The involvement of USU and Air Force medicine to the NCA integration effort is critical and ongoing.

In order to be successful with MEDCEN integration we must continue to provide the services and perform the functions that NNMC and WRAMC do best: care of our OIF/OEF wounded heroes and patient and family-centered care. Warrior care has challenged both MEDCENs to meet the evolving demands of providing care for traumatic brain injured, amputee, complex psychiatric patients, and polytrauma patients and their families. We are at the tip of the spear in these areas! The care of our service men and women injured during the defense of our nation has been and will always be our mission and is a crucial part of our vision as we integrate the MEDCENS. Incorporation of family-centered care into this new paradigm is vitally important to the success of MEDCEN integration that we continue to provide quality primary and specialty care to all of our beneficiaries in a patient and family-centered environment. DoD has counted on us for their comprehensive health care needs.

The vision of the MEDCEN integration must be converted into an executable plan. As we maneuver through this very complicated process, we must evolve to meet both NCA and MEDCEN integration challenges. Walter Reed and Bethesda's Deputy Commanders for Integration (DCI) and their teams will focus on MEDCEN integration while the Office of Integration will focus on NCA integration issues. The DCIs will work aggressively toward forming integrated functions between NNMC and WRAMC and add granularity to the integration planning and process. Representative leadership from both facilities will meet as the Joint Executive Board (JEB). Co-chaired by the DCIs, this group reports directly to us. Their task is to execute integration. They will either make decisions or refer matters to us with recommendations for our final approval.

These are exciting times and the realization of our shared vision for the new WRNMMC as a world class academic facility focused on the highest quality care, health professional education and research requires your continued support and enthusiasm. Our goal of an integrated health care system depends on the successful, collaborative integration efforts of the MEDCENs and the NCA as we move forward together. We must remember the qualities, traditions and reputations of great service that made NNMC and WRAMC the icons of excellence they are today and capitalize on them as we move forward with MEDCEN integration. ■

For the first time in the 98 year history of the hospital that has served as the center of gravity for military medicine, a woman who is also a nurse has been appointed Commander of the Walter Reed Health Care System (WRHCS).

With the media spotlight on the Military Health System (MHS), Colonel Patricia D. Horoho took time out of her very demanding schedule to offer insight on how she plans to preserve the legacy of Walter Reed during a media whirl wind all while moving full speed ahead with the integration activities.

In this hour long interview we get to know the leader. We also get to know about the woman, nurse, mother, and wife behind the uniform. We welcome the new Commander of Walter Reed Health Care System.

Thank you for taking time to meet with us.

Congratulations on being appointed Commander of Walter Reed Health Care System (WRHCS)! You make us proud.

OOIN:
Tell us… what is your vision as Commander of WRHCS?

PH:
Are you referring to my vision in relation to BRAC (Base Realignment and Closure) or my entire vision?

OOIN:
Your entire vision…

PH:
The past challenges have afforded WRAMC and the AMEDD tremendous opportunities to make changes in business processes, break down bureaucratic barriers, institute a culture change and refine and shape the direction we are heading in the future. I believe we have the capability to become the center of excellence for continuity of care and to really redefine, for not only the military, but redefine for the civilian healthcare industry, exactly how you manage the health of a population from the time they enter your facility thru their in-patient and out-patient stay until a final determination is made as to their status.

So, I see this as an exciting opportunity. My vision is for us to become a very flexible, agile, organization that builds upon the past 98 years of providing premier, healthcare and to build upon that base and to recreate ourselves. We have the opportunity to meld the large primary care mission with our tertiary care mission so we evolve into a fully integrated healthcare delivery system that supports continuity of care for all beneficiaries.

OOIN:
In context with your vision, what is your outlook on integration related to the medical centers (WRAMC/NNMC)?

PH:
Actually, I see integration as being just one step that we need to take towards getting to that vision. We would be melding the best of what Bethesda has to offer with what the best of Walter Reed has to offer in support of that vision. Subsequently, we'll have a National Capital Area that is focused on continuity of care and we'll bring in all of those Military Treatment Facilities in our market to be able to capitalize on the clinical care and types of services they provide. In this way we can better meet the needs of all our warriors and their family members. So, I see integration, to be honest, as a tool that leverages our capabilities here to be able to shape the direction of the provision of healthcare in the National Capital Area in the future.

OOIN:
You kind of answered my next question, which is "what is your outlook on integration related to the National Capital Area (NCA) Military Health System (MHS)?"

PH:
I see this as one big system. I know we're working towards functional integration between the two medical centers, but to be honest, I look at it as one big system. The two medical centers are very huge players in the NCA healthcare system, but we cannot think of the MEDCENs as separate from the larger NCA system. This system provides care to DoD beneficiaries and focuses on training and educating soldiers so we have the right skill set to meet our mission on the battlefield and to provide premier medical care in our MTF's.

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OOIN:
You speak so passionately about this, so I must ask a question that I hadn't planned to ask. Why do you see the whole system as being so important?

PH:
Because I think when we look at taking care of our warriors— and when I say "warriors"— I see warriors as Army, Navy, Air Force, Marines, National Guard, and their family members. For us, as a nation, to ensure that we have homeland defense, as well as to be able to support the global war on terror, it means we have to be concerned with the health of all our services, and their family members. To do that, it has to be an integrated approach and I see the National Capital Area as a tremendous test-bed for that concept of how do you take the best of every single DoD healthcare facility in the NCA and combine those qualities so that their is a reduction in redundancy, an increase in efficiency and an academic environment that supports research, health professions education and continual advances in military medicine.. I'm very excited that we have the opportunity to define how healthcare will be practiced in the future. I don't see Walter Reed as closing. I see Walter Reed as reshaping itself and what we're going to do.

OOIN:
I love your choice of words.

PH:
You know it's interesting. Someone made a comment to me that the BRAC (Base Realignment and Closure law) used the language that Walter Reed is closing. And I said, "Walter Reed is not the bricks-n-mortar. Walter Reed is a living, breathing, viable organization that is committed to providing the best healthcare that we can to help our beneficiaries, so regardless of where we do that, what we have to focus on is what we do and not where we perform it at".

> "Walter Reed is not the bricks-n-mortar. Walter Reed is a living, breathing, viable organization that is committed to providing the best healthcare…"

OOIN:
You are the first female appointed Commander of the Walter Reed Health Care System, as well as the first nurse. You will forever be known for that. It's safe to assume that this will remain a part of your career legacy.

As the first nurse and female to command Walter Reed, how has your perspective changed or shifted or has it?

PH:
I don't know if it's changed or shifted. However, I am very much sensitive to the fact that I am the first female and the first nurse. I'm sensitive to it from many perspectives. I'm sensitive to it changing a culture in which some people may feel uncomfortable with that. I want to be very sensitive to that. I'm very sensitive to the population out there who is very excited about this, because it is cutting in-roads for those that may not have had that opportunity in the past. There are people that are very excited, because whenever someone does something new and breaks down a barrier it creates an in-road for someone else to come along and be able to do that. So, I'm sensitive to that as well.

But probably what I'm most sensitive to— it's not being a female, it's not being a nurse— it is being a leader. What I think the most important thing an organization needs is someone who understands that the awesome opportunity that comes with command is the humble feeling of realizing that you're there to serve. You're serving the employees that work in that organization. You are serving your patient population that comes to receive care. You are serving all the other constituents that have some affiliation with your organization that you command. So leadership to me and command combined, is the opportunity to serve. Therefore, how I see this is that I am being afforded the opportunity to serve an organization that's been through a tremendous amount of turmoil. My focus is to help the organization heal and to realize that we have such a phenomenal opportunity to shape the future direction. This I strongly believe. I think this is the most exciting time that we have within military health care. We have the entire Army behind us on re-sourcing, breaking down barriers, and helping with policy changes. We have Congress focused on putting the right legislation in place and re-sourcing the necessary improvements appropriately. We also have the Department of Defense's support, as well. Now you have all of those forces working together towards barriers being broken down. We just have to make sure we're working together as a team to put the right fixtures in place and effectively monitoring and communicating those changes.

That's a kind of convoluted way of answering it, but knowing that I'm the first woman and the first nurse isn't going to change my leadership style. My leadership style has been grounded in realizing that when we lead we're serving, so that's my focus. I'm focused on having integrity, being accountable to those that you serve, to my superiors, and to myself. It's also about focusing on trust. It's about gaining the trust of those that you're about to lead, gaining the trust of the American public, Congress, as well as our patient population.

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OOIN:
You talk about trust. Again, excuse my diversion from the questions I had prepared, but I must state that this all seems so divine how everything lined up. To give our readers further insight and I know you've just expounded upon this a little, but what does this opportunity mean to you?

PH:
First, I believe that everything that has happened in my personal life, in my military career, and in my professional career, happened because that is the direction God wants my life to go. So, I believe that every challenge we go through is God's way of providing you with the skill-set that you need to be able to either help someone else out, to gain the sympathy or empathy needed to recognize a need in another person or organization, as well as to build the character you'll need to have to be able to weather those storms, as a steady and strong leader in the face of adversity. That's our challenge: to be able to keep an organization moving forward in the midst of turmoil and in the face of adversity and to seek out those windows of opportunities that are created during turbulence and uncertainty. Everything that's occurred in my personal life and military career, I believe it's been God directed. I do see this opportunity as this is where God wants me to be. So, I pray everyday that he continues to give me the skill-set and compassion to lead this dynamic organization.

OOIN:
You've pretty much answered the question I had prepared to ask you next, but I'll ask anyways to gain further clarity. How do you believe your past assignments prepared you for this monumental assignment?

PH:
I believe that everything is a building block. I think everything we do provides us with skill-sets to put in our tool-kit, so we can draw from it at our next assignment. Every position that you have allows you to look at an issue from a different perspective, because you gained that past experience. There hasn't been one job the Army has placed me in where I haven't grown tremendously. I believe that is apart of what we do to be good leaders. Life is a continual growth process.

I believe you have to be very secure as a leader to realize where you have weaknesses and to feel comfortable enough to surround yourself with individuals who have strengths that counterbalance your weaknesses.

OOIN:
Speaking of legacies and we talked about this a little, but how do you plan to preserve the Walter Reed legacy?

PH:
That is a very good question. I see the Walter Reed legacy historically as having continually redefined how healthcare has been delivered for the past 98 years. We've drawn upon lessons learned from wars in the past. Out of the necessity to do our very best for our warriors, new ways for doing medicine has been continually created and it's been intertwined with research and with our graduate medical education programs. To continually remain on the cutting-edge of the provision of healthcare is the legacy of Walter Reed. Every war has allowed Army medicine and military medicine to further define how we provide care and to further define how civilian healthcare is delivered, as our expertise is shared with the civilian community. So the legacy of Walter Reed is the continual growth and advances in healthcare. That's what we will continue to do. The name is a world-renowned name. Our charge is to continue to attract the best healthcare professionals and administrators that we can, so we are focused on advancing healthcare, because that's exactly what our American public and those that sacrifice so much deserve.

> "I don't think you can have a premier, academic, tertiary care center that has a robust primary care mission, without having a close affiliation with a university."

OOIN:
As the former Deputy Commander for Nursing, you played an active role with the Joint Executive Board (JEB). How do you expect your role with the Joint Executive Board (JEB) will likely change as Commander of WRHCS?

PH:
It will dramatically change, because I have a deputy commander for nursing who is looking at nursing issues. I see the deputy commander for nursing and the deputy commander for clinical services as one team and united in their focus on clinical care, because healthcare is not a silo. Healthcare is not comprised of "medical care" and "nursing care", its "clinical care". The perspective will be that those two deputies will be looking at the provision of care and my perspective as the Commander will be looking at integration from all aspects of the organization, from the administration piece, to the process piece, to the human capital piece, to the clinical. So it will have that entire big picture perspective as a Commander.

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I will be working very closely with my counterpart at Bethesda, so we ensure both leaders are working towards the same vision.

OOIN:
In the vision statement written by the MHS FLAG leadership it states "…the tri-service Walter Reed National Military Medical Center at Bethesda will be a world-wide military referral center and together with the Uniformed Services University (USU), will represent the core of" the integration health system.

How do you foresee USU playing an active role in the integration with Walter Reed and National Naval Medical Centers?

PH:
I see USU as being a vital member of the team. I don't think you can have a premier, academic, tertiary care center that has a robust primary care mission, without having a close affiliation with a university. USU has been that for the military healthcare system. I think it's vital that we tap into the expertise of their researchers, professors, and staff as well as tap into their educational technology resources. Ideas between WRAMC/ Bethesda staff and USU staff should allow all to take advantage of free-flowing ideas and resources. In order to get to that end-state, we can't do it without USU.

> "I do *not* look at it as a purple-suited Service. I strongly feel that the strength of what our Services have provided over the years draws strength from their unique mission."

OOIN:
What do you envision the MHS will look like in 2011?

PH:
I envision it as being a tri-service system that has integrated processes that allows for the free-flowing movement of resources, personnel, and monies. We'll need to be agile enough to ensure that where our patient and beneficiary population are located is where our services are. I do not look at it as a purple-suited Service. I strongly feel that the strength of what our Services have provided over the years draws strength from their unique mission and culture. I feel the future and the success of military healthcare will be capitalizing upon that uniqueness's and bringing out those strengths and having increased the interoperability between all of our Services. I believe the end-point will be a place where we've capitalized on the strengths; we've reduced the inefficiencies of the system, and enhanced interoperability.

OOIN:
Since this is where you'd like for us to be, I'm assuming that you don't feel we're anywhere close to that now. Making this assumption, what do you feel impedes us from being there?

PH:
I believe there are numerous things. First, dollars don't flow. Dollars are stove-piped. Therefore, there is no incentive for Commanders to move assets or personnel to where the patient population is located. Currently there is actually a disincentive to shift workload where the patient population is. You're actually penalizing a command. We have not at all redefined our business processes and the rules of engagement within the National Capital Area, so that its incentive based for people to shift their clinical assets to where the workload is. Second, we don't give credit to the source of where the workload is coming from. We give credit to where the work is being done. For example, if I take one of my surgeons and shift him/her to another facility to do work, I then get accounted for having low productivity here and the facility I send that surgeon to gets to count that productivity as being theirs. These are the rules of engagement that need to change. I also think that our personnel system needs to become more flexible so we can move our civilians around if we need as well as our military.

OOIN:
I recall you speaking so passionately about these challenges as the Commander of the Dewitt Army Community Hospital (DACH) during the Commander's Executive Board (CEB) meetings. Now that you're the Commander of WRHCS, how do you plan to go about breaking down those barriers on an operational and tactical level?

PH:
This is probably from the same perspective to be quite honest, it's just now I'm looking at it as the Commander of a medical center. I think it requires us as the Multi-Service Market to relook demographics, re-look our business plans, and identify what needs to be in place to support the end-state that we envision and then take that through Health Affairs and through the Tricare Management Activity to request relief of those policies. We need to use the National Capital Area as a test site, so we can tweak it to see what "right" looks like. Going up through the Multi-Service Market Office (MSMO) and those higher echelons is the right way to do that.

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OOIN:
As change remains constant for the Walter Reed Healthcare System and for the MHS as a whole, the personal demands must sometimes seem endless.

How does becoming Commander affect your quality of life and the personal relationships (i.e., children, spouse, etc.) you have?

PH:
One, I have an extremely supportive family or I wouldn't have been able to continue with my military career. At every juncture prior to accepting a job we do sit down as a family to reassess whether or not this is something the family can support and if it's still in alignment with our family goals. We have to make sure, because we know that with each commitment that we make, it requires long hours and personal sacrifices. I'm a firm believer that you have to work very hard to put in time with both your work life and family life. I probably give up a lot of sleep, but it's the same anyway you look at it since we all only have 24 hours a day. What I try very hard to do is to set priorities and identify those things I won't miss. If my children have major events at school, I don't miss those. We will have our church time. You just have to set priorities in both your family life and your professional life. You must look at how much time you can allocate and adjust depending on the demands in both settings. I get constant feedback from my children and husband as to whether or not I'm keeping things in perspective. Then I do take the time early in the morning to reflect with God to ensure that I'm grounded. Sometimes that may only be a couple of minutes, but it does keep you focused

> "An organization in order to be viable has to experience continual change in process improvement and progress. If you don't do that you become irrelevant."

OOIN:
So I take it that you understand how important it is take care of yourself to ensure you have something to still offer both lives?

PH:
Yes, its funny you say that. I can't say enough how supportive my husband and kids are with this. As long as they are supportive I'm able to continue with being a wife, being a mom, as well as being a Soldier, officer and leader. I do see myself in all of those roles and sometimes you have to give more to one role than the other. It's a constant readjustment on a daily basis as to what's the higher priority for that day.

OOIN:
Speaking of support systems, how do you feel the Organizational Development Practitioners (ODPs) can assist you in achieving your integration goals?

PH:
Oh, I'm a real firm believer in organizational development. I believe change is so key to any organization, especially when an organization is reshaping its future in a dramatic way, as we are. An organization in order to be viable has to experience continual change in process improvements and progress. If you don't do that you become irrelevant. To facilitate change, since change has to be facilitated, because you're dealing with some people who thrive on it, some who resist it, and some who are stressed by it. I see ODPs being instrumental in facilitating the change process, with assisting certain groups of individuals in becoming aware of their environment and that change is occurring around them. They will support us in understanding the affects of changing processes, the affect of personnel shifts, and the best mechanisms needed to institute change. They're also critical as an objective support system, because they're not tied to the process. They assist with moving teams and groups along. They're great with team-building and communicating the message. In order to implement change at the level we're doing, we absolutely need ODPs to do that.

OOIN:
You spoke early about how you see leading as serving. With all the change that's occurring around you and those you will serve, how do you plan to keep your people informed on the progress of integration?

PH:
This is probably our biggest challenge. To be honest, communication in any organization that is this complex and this diverse is very, very challenging. We're looking at outside agencies. We're working on a marketing-communications strategy. We've got a group that is putting together a strategic communications plan. We're looking at very diverse approaches as to how we facilitate internal communication of all issues. We're paying close attention to how we want to market those messages and which ones we need to get across to our constituents, so we package the message to make it understandable. The same theme needs to be packaged differently for the different audiences we're communicating to. So we're in an initial phase of developing all those plans. To me, this will make or break what we're trying to do. **(to be continued…)** ■

Stay Tuned Next Month to See How COL Horoho addresses the #1 burning question for those who travel onto the Walter Reed campus!

Working Better *Together*—

The NCA Integration Steering Committee

By: Barbara J. Flint, PhD, Technical Writer and Historian, Office of Integration

Initial Architecture:
To foster the cohesion necessary to achieve integration, senior military leaders created a multi-service and multi-functional team with representation from all Services, and from every Service level— Flag to Enlisted**.** The Integration Steering Committee (ISC) was designed as a true Tri-Service structure. According to Maj. Gen. Kenneth L. Farmer Jr., working with the Office of Integration (OI), the ISC "is to create the how, when, and where recommendations" for integration. What follows is a snapshot of the ISC— as it develops principles, processes and a plan for creating an Integrated Delivery System (IDS) for the Military Healthcare System (MHS) in the National Capital Area (NCA).

Following the 13 May 2005 BRAC announcement, a team of healthcare professionals, under the direction of the NCA Multi-Service Market Office (MSMO), gathered to assess various NCA BRAC scenarios for future MHS facilities. They quickly realized a plan was essential for the integration of healthcare services between Walter Reed Army Medical Center (WRAMC) and National Naval Medical Center (NNMC) and between the North and South campuses. In August 2005, the Flags announced a joint Vision Statement for the market and later established an NCA OI to spearhead the integration effort. The ISC, comprised of three task-defined subcommittees— Clinical, Healthcare Operations and Graduate Medical Education— was formed to focus on integration. Since October 2005, the ISC has met weekly to review the opportunities and constraints related to the merger of healthcare services within the NCA.

At a MSMO organized offsite on October 25, 2005, the ISC was provided the basic outlines of its charter and its purpose: The "*Integration Steering Committee will oversee the integration process, define overarching integration guidelines for the NCA . . . . The ISC will discuss integration issues and make decisions to move integration forward to achieve the milestones for functional integration of the MEDCENs, USUHS and the NCA MHS Region.*" The ISC was tasked with drafting the Functional Integration plan for an integrated healthcare delivery system (IDS) in the NCA.

The ISC included key members from NCA's Military Treatment Facilities (MTFs) and the Uniformed Services University (USU). The Subcommittees included experienced clinical and/or administrative leaders and subject matter experts from the Army, Navy, Air Force and USU. ISC, chaired and staffed by the OI, researched and evaluated methods for merging WRAMC and NNMC and for creating integrated departments well before the mandated BRAC deadline.

During its first six months of operation, between October 2005 and April 2006, the ISC set and met an aggressive schedule for Functional Integration. The ISC completed a Blueprint for Integration that was approved by the Flags on 23 February 2006. The Blueprint set forth key concepts, working assumptions, and Major Milestones with dates of completion for Functional Integration. The document stated: "The *Office of Integration will direct the integration effort across the NCA. Implementation will occur through the involved commands . . . . [T] here will be a single strategic vision and direction for the NCA."* ISC, guided by the OI, was to draft the strategic plan that would bring this vision into reality.

Following the Flag review and approval of the Blueprint in February 2006, the ISC was restructured to exclude the Commanders who were then reorganized into the Integration Advisory Council (IAC). The ISC and OI were to focus specifically on integration planning. The IAC and the Commanders Executive Board (CEB) would accept increased responsibility as integration shifted from planning to implementation. Next, the original three subcommittees of the ISC (Clinical, Healthcare Ops and GME) were expanded to include Communications, Administration, Nursing, Information Services and Research. At the suggestion of COL Fitzpatrick, the membership of the subcommittees was adjusted to ensure sufficient numbers to perform the impending tasks. In addition, as each Subcommittee selected its chairs and its co-chairs, an attempt was made to include equal representation from the Services.

The immediate focus of the ISC's efforts was the first two of the four Major Milestones established in the Blueprint: (1) Functional Integration of the MEDCENs by 2nd quarter 2007 and Functional Integration of specialty and inpatient care by 4th quarter 2007. The initial actions for drafting a strategic plan were scheduled for an April 2006 completion. The ISC took the "big picture" approach generating short and long-term goals, identifying steps for achieving and for measuring progress toward the goals. ISC, with OI oversight, generated both clinical and operational goals and objectives which, the ISC stressed, "will developed the most efficient and effective means for consolidation." By 14 April 2006, in less than three months, ISC had goals and objectives completed from all of the Subcommittees and ready for presentation to the Flags.

Flag Briefs:
In Feb 2006, the Flags had approved the Blueprint and the Basic Strategic Goal for 2006-2007 -- Functional Integration. The Goals and Objectives Brief, which ISC presented to the Flags on 23 April 2006, was vital to the architecture of Functional Integration.

The ISC and OI agreed that "the committee is not a decision making body but an advisory/consultative body that makes recommendations to the Flags." But, on the other hand, many ISC members thought, "it should also be made clear that the Flags need, and should be looking to, the ISC to provide leadership and direction within the integration process." A subsequent review of the brief noted that the Flags were pleased, but then only the positives had been emphasized. It was also noted "they seemed to be waiting for us to bring our problems to them; [The Flag Officers] "might want to hear a little more about the challenges." Most of the ISC members agreed that there would be plenty of time to present the challenging issues in the coming months.

Scheduling incompatibilities and the demands of commands determined the frequency of a joint Flag session. But, the goals and objective received rapid approval and thus allowed the ISC to move forward. On May 30-31 2006, the OI sponsored a joint Offsite to permit a review of the goals and objectives by the commands and to allow "the planning team to develop a solid plan for integration." A major outcome of this May 2006 Offsite was the Flags' delineation of their Four Overarching Objectives for Functional Integration. With these major command objectives in place, ISC devoted subsequent effort towards crafting a Plan of Action and Metrics (POA&M) to support the Flags' objective. By September 2006, the ISC had produced and received Flag approval for the 2006-2007 WRNMMC Strategic Plan.

Deliberative Ground Rules:

ISC members realized that there were a host of steps and actions that would have significant impacts on their progress and on their successes. Rules, regulations and instruction which differed for each Service posed serious challenges to integration. The general attitude was "problems can be solved and difference must be resolved" to achieve the goal. Critical to success, however, was how members of the ISC interacted with one another. Accordingly, ISC and OI established ground rules to remove deliberative barriers that could hinder this very important work.

ISC's Committee members agreed that uniformity in planning and presentation required a standardized process. Hence, the ISC readily adopted guidelines presented by CAPT Louis Damiano for an Annual Planning Process. The design, the group agreed, "would keep everyone moving in the same direction and provide a uniform means for identifying and tracking goals and objectives." Furthermore, the ISC agreed to operate by consensus and to make every possible attempt to see that any "unresolved or conflicting planning assumptions or other issues will be resolved by the ISC." In cases where a consensus recommendation was not reached, and if "there are differences of perspectives reflected within the discussion" both the majority opinion and the minority opinion will be presented to the Flags.

From the outset, it was established that all views could be represent and expressed. However, to ensure alignment, it was forcefully stressed, "you are not an advocate of your group's position but a representative to make sure that a clear and detailed picture of your task or service area is provided." Paradoxically, ISC participants were told that they had a responsibility to their constituencies. It was important to know what the constituencies were thinking and to make sure that they were aligned as integration progressed. Furthermore, it was advised that ISC's member be very "sensitive and keep abreast of moods and mind-set through conversations, dialogue and interviews with key the individuals" including the civilian leadership.

Each and every participant was cautioned to take an opened-mind approach and "to hear the experience of others with regard to integration best practices." This "hearing" was especially critical for dealing with those on the clinical frontlines. ISC, it was stressed, had to make sure that "the clinicians on the front-line know that the Integration Steering Committee exists and that it is moving ahead to shape the integration strategy." This would increase the probability that the clinicians would support ISC proposals, but also, the clinicians "... need to know that, if they don't get together and formulate their recommendations, then someone else is going to do it for them." Furthermore, the ISC insisted that each person "continually represent to your command . . . that things are not going to remain as they are . . . "

The seriousness of ISC's commitment was very evident in the time spent in research, in data gathering and in deliberation. ISC, OI, and the Subcommittees "mined" the work of other groups with respect to data, discussions, models, and recommendations on integration or similar medical mergers. It was crucial for the ISC to buttress Functional Integration plans with research, with data and with sound evidence. But, even more importantly, data and documentation served as proof that "we have agreed to utilize the 'best' as a guide for standardizing, unifying or merging clinical and operational systems or processes." For the greater good, participants within the ISC were encouraged to bring "our best ideas, and use our most inventive methods" to create... a whole clearly better than the sum of the parts.

Success Indicators:

The ISC, with its aggressive timeline, immediately produced notable achievements. The Strategic Plan provided the foundational work for the success of Function Integration in the coming years. Successful pilot projects, communication techniques, selection and placement procedures made possible clinical and operational consolidation. As LTC David Bitterman noted: "Just getting all the organizations to come to the table and to reach consensus on various concepts of operations is a success..." In light of this success, perhaps the most notable achievement of the ISC, during this formative phase, was to develop a mind-set and embrace the "different view" necessary for consolidating the systems unique to each Service and for providing a model of behavior that "structures and images" an integrated delivery system. ■

(**To be continued...**)

Resistance to Change

By: Paco Valencia, MSOD, ODP, Office of Integration

Experience and research into classic references used by ODPs in their practice have shown that the process of creating change is more difficult than it might seem. It is tempting to think of an organization as a large machine where parts can be replaced at will. On the contrary, the task of changing the behavior of organizations, groups and individuals often turns out to be difficult and frustrating. This is because there are several problematic tendencies that often surface when organizations undergo change, and clues about this can be found in classic organization literature.

First is the problem of *resistance to change* (Watson, 1969; Zaltman & Duncan, 1977). Any individual faced with change in their organization may be resistant for a variety of reasons. People have need for a certain degree of stability or security. While we all want to feel that we are in control of ourselves and our surroundings, change that is imposed reduces our sense of autonomy or self-control. In addition, those who hold power in the organization have a vested interest in the status quo. Therefore, they may resist change because it threatens that power. Individuals may resist change for ideological reasons; they truly believe that the way things are is better. Whatever the source, individual and institutional resistance to change must be overcome before a new vision can be successfully implemented.

This problem implies a need to *motivate changes* in individual's behavior. Change leaders must first recognize and acknowledge that within the organization that resistance to change is normal. Then, to motivate behavioral change the leaders must ensure mechanisms to support the process of buy-in to a new vision. That includes hearing those things that keep people stuck in the past, addressing people's concerns, as appropriate, and in a most respectful manner taking care of those cherished things that will be lost, such as institutional pride, relics, leaders, mentors, culture, status, jobs, etc. In addition, people need to have confidence that change leaders realize and can demonstrate that people matter. These are essential factors aspects that help to eliminate natural resistance to change. Taking care of these elements will help get individuals to behave in ways consistent with both short-term goals and long-term strategy.

A second problem is ***organizational control***. Change disrupts the normal course of events within an organization. It undermines existing systems of management control, particularly those developed as part of formal organizational arrangements, such as reward systems, authority structures, reporting mechanisms, formal and informal communication, process and policies. Change may make these systems irrelevant and/or inappropriate. As a result, during a change, it may become easy to lose control of the organization because business will no longer be done in the same way. As goals, structures, and people shift, it becomes difficult to monitor performance and make course corrections, as normal. In fact, some people may even have difficulty gaining access to information about the new course.

Managing the transition of structure and function is critical. Organizational arrangements must be designed and used to insure that control is maintained during and after the transition. They must be specifically appropriate to the transition period rather than to the current or future state. Successful management of the transition period implies effective communication about everyone's role and function in the transitional state, which may take many forms. Further, it requires attention to the 3 Fs -- form, frequency and format -- customized for effectiveness in that particular organization.

Then there is the problem of *POWER!* Any organization is a political system made up of different individuals, groups, and coalitions competing for power (Tushman, 1977; Salancik & Pfeffer, 1977). These dynamics become even more intense as the old order is dismantled and a new order emerges. Individuals and groups tend to take action based on their perception of how change will affect their relative power position in the organization during transition.

Additionally, they will use their influence to protect aspects of the organization they believe should be retained. The *political dynamics of change need to be shaped* so that the power centers develop support for the change, rather than block it (Pettigrew. 1978).

Action Steps

If change is to be effective**,** then all three problems— resistance, control and power— must be addressed. Specific action steps related to each problem can be taken to improve the chances of achieving effective change. These steps can lead to answers for such questions as: What does leadership want? What is the vision? Will my opinions be valued? How are decisions made? Where will I end up?

Motivating Change

The first action step is to *identify and surface dissatisfaction with the current state.* As long as people are satisfied with the current state, they will not be motivated to change: people need to be "unfrozen" out of their inertia in order to be receptive to change (Lewin, 1947; Bennis et al, 1973).

The second action step is to build in *participation* in the change. One of the most consistent findings in the research on change is that participation in the change process tends to reduce resistance. It also builds ownership of the change, and thus motivates people to make the change work (Coch & French, 1948; Vroom, 1964: Kotter & Schlesinger, 1979). On the other hand, participation has costs, since it involves relinquishing control, it takes time, and may create conflict. For each situation, different degrees of participation require calibration as to what will be most effective (Vroom & Yetton, 1973).

A third action step is to build in *rewards* for the behavior that is desired both during the transition state and in the future state. Our understanding of motivation and behavior in organizations suggests that people will tend to be motivated to behave in ways that they perceive as leading to desired outcomes (Vroom, 1964; Lawler, 1973). This implies that both formal and informal rewards must be identified and tied to the behavior that is needed, both for the transition and for the future state.

Finally, people need to be provided with the *time and opportunity to disengage from the present state.* Change frequently creates feelings of loss, not unlike a death. People need to mourn for the old system or familiar way of doing things. The process of dealing with a loss and going through mourning takes time, and those managing change should take this into account.

Managing the Transition

One of the first and most critical steps for managing the transition state is to *develop and communicate a clear image of the future* (Beckhard & Harris, 1977). In the absence of a clear image of the future, rumors develop, people design their own fantasies, and they act on them. Therefore, as clear an image as possible of the future state should be developed to serve as a guideline, target, or goal. Similarly, it is important to communicate information to those involved in the change, including what the future state will be like, how the transition will come about, why the change is being implemented, and how individuals will be affected by the change.

The second action step involves a number of different activities. *Organizational arrangements for the transition* need to be explicitly considered, designed, and used. In particular, the following organizational arrangements are important for managing the change:

a. Transition Leaders. These persons should have the power and authority needed to make the transition happen.
b. Resources for the transition. Major transitions involve potentially large risks for organizations. Given this, they are worth doing well and it is worth providing the needed resources to make them happen effectively. Resources such as personnel, dollars, training expertise, consultative expertise, etc. must be provided for the Transition Leaders.
c. Transition Plan. A transition is a movement from one state to another. To have that occur effectively, and to measure and control performance, a plan is needed with benchmarks, standards of performance, and similar features. Implicit in such a plan is a specification of the responsibilities of key individuals and groups.

Another action step for transition management involves developing feedback mechanisms to provide transition managers with information on the effectiveness of the transition and provide data on areas which require additional attention or action. Devices such as surveys, sensing groups, interviews, as well as informal communication channels need to be developed and used during this period.

Shaping the Political Dynamics of Change

If an organization is a political system composed of different groups each competing for power, then the most obvious action step involves ensuring or developing the support of key power groups. For a change to occur successfully, a critical mass of power groups has to be assembled and mobilized in support of the change.

Resistance to Change (continued)

A major factor affecting the political terrain of an organization is the behavior of key and powerful leaders. Thus, a second major action step involves using leader behavior to *generate energy in support of the change.* Leaders can mobilize groups, generate energy, provide models, manipulate major rewards, and do many other things that can affect the dynamics of the informal organization.

The third action step involves *using symbols and language to create energy* (Peters, 1978; Pfeffer, 1980). By providing a language to describe the change and symbols that have emotional impact, it is possible to create new power centers or bring together power centers under a common banner.

Finally, there is the need to *build in stability*. Organizations and individuals can only stand so much uncertainty and turbulence. The increase of anxiety created by constant change thus has its costs. An overload of uncertainty may create dysfunctional effects, as people may begin to panic, engage in extreme defensive behavior, and become irrationally resistant to any new change proposed. One way of dealing with this is to provide some sources of stability that stay the same and serve as "anchors" for people to hold onto (structures, people, physical locations, etc.). These anchors provide a means to define 'the self' in the midst of turbulence. While too many anchors can encourage resistance, it is important to provide some stability. Thus, those stabilizing aspects of the organization that will remain unchanged, during a transition period, need to be identified and communicated to organization members.

So what does all this have to do with medical integration of the National Capital Area and WRAMC and NNMC medical centers? Integration means significant change and resistance to change is normal. If, however, creating a premier, world class medical delivery and health education system, second to none in the world is a worthy vision, then we are all responsible for addressing these problems and finding a way to embrace change. The Nation is looking to us to do it! ■

** Note: References used are classics that ODPs refer to for practice

References:

Beckhard. R. & Harris, R. (1977). *Organizational transitions.* Reading. Massachusetts: Addison-Wesley.

Bennis. W.G., Berlw, D.E., Schein, E.H. & Steele, F.L (1973). *Interpersonal dynamics: Essays and readings on human interaction.* Homewood, Ill.: Dorsey Press.

Coch, L. & French, J.R.P., Jr. (1948). Overcoming resistance to change. *Human Relations, 11,512-532.*

Kotter, J.P. & Schlesinger, L.A. (1979). Choosing strategies for change. *Harvard Business Review,* (March-April), 106-114.

Lawler, E.E. (1973). *Motivation in work organizations.* Belmont, California: Wadsworth Publishing Co.

Lewin, K. (1947). Frontiers in group dynamics. *Human Relations,* 1,5-41.

Peters, T.J. (1978). Symbols, patterns, and settings: An optimistic case for getting things done. *Organizational Dynamics,* (Autumn), 3-23.

Pettigrew, A. (1972). *The politics of organizational decision-making.* London: Tavistock Press.

Pettigrew, A. (1978). Towards a political theory of organizational intervention. *Human Relations,* 28, 191-208.

Pfeffer, J. Management as symbolic action: The creation and maintenance of organizational paradigms. In L.L. Cummings & B.M. Stow, eds. (1980). *Research in organizational behavior* (Vol. 3), JAI Press.

Salancik, G.R. & Pfeffer, J. (1977). Who gets power and how they hold on to it: A strategic-contingency model of power. *Organizational Dynamics,* (Winter), 3-21.

Thompson, J.D. & Tuden, A. (1959). Strategies, structures and processes of organizational decision. In J.D. Thomspon et al (eds.). Comparative studies in administration. Pittsburgh: University of Pittsburgh Press.

Tushman, M.L. (1977). A political approach to organizations: a review and rationale. *Academy of Management Review,* 2, 206-216.

FEATURE SPOTLIGHT

Ms. Dawn Marvin–
Department Head, Marketing & Communications
National Naval Medical Center (NNMC)

What Will Our Emblem Look Like? Part II of the Series

In a recent issue of this newsletter, we reported on the reasons why we cannot yet announce or use a new logo or emblem that represents the future Walter Reed National Military Medical Center (WRNMMC.)

One of the major reasons is that the Joint Commission considers the publication of a "common" emblem as a signal to the community and to our staff and beneficiaries that we (WRAMC and NNMC) are now one entity. Although we are making steps daily toward functional integration, we are not yet one entity. Also, we want to do this right and that takes time since this emblem will stand for the biggest consolidation of military medical facilities in history.

The words "logo", image brand or "emblem" are sometimes used interchangeably, but they are slightly different. The correct term in the military is "emblem". However, an "emblem" used in conjunction with some image branding techniques and collectively referred to as a "logo," is becoming more common in the military. Image branding or image recognition consists of a series of visual images and/or tag lines used repeatedly, separately or in conjunction with each other, so that those images become synonymous with the organization they represent.

To ensure that the branding image truly represents WRNMMC, the initial design concepts are subliminal and are based on the vision, mission and goals of the organization. When translating intellectual or subliminal concepts into visual reality, certain elements of design are used that are believed to represent and elicit subliminal emotional responses such as strength, security, military history, cutting-edge medicine, care of our troops, forward thinking, etc. The five basic elements of design (color, composition, foreground/background, line and volume) are used to define those concepts..

The Institute of Heraldry will assist with iconology and military symbolism. The Institute has been a part of the Army for approximately 90 years. It provides services related to official symbolic items such as seals, medals, insignia, badges, flags authorized for official wear or display by government personnel and agencies including the Executive Office of the President. For example, the Institute can tell you something as basic as the President's seal is always shown with 13 stars, or as obscure as the laurel leaf is an ancient pagan symbol of healing. Although the Institute is "owned" by the Army they assist all military services.

The Institute will register an approved new military emblem; so that no other military institution or organization can use or abridge it. If you're in any branch of the military, there's a good chance that the military patch on your shoulder was researched and "approved" by the Institute. To learn more about the Institute of Heraldry visit their web site at http:\\www.tioh.hqda.pentagon.mil.

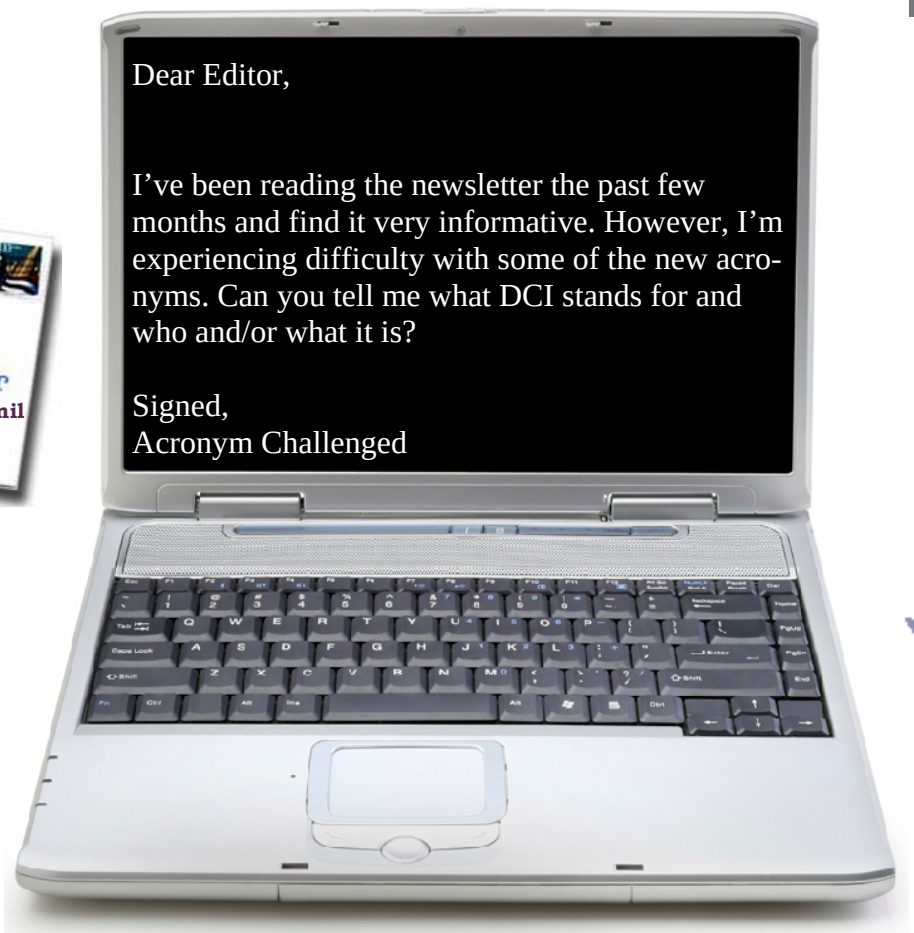
When the logo concept is ready for the design stage, the graphic designer takes into account all of these considerations. In addition, technical considerations are checked such as assuring that the design will hold high resolution in HTML, on coins, on embroidered patches and in enlargement, etc. Usually, a minimum of three designs that meet all reproduction, historical and quality control standards, are submitted. For ease of comparison, "art boards" are produced that show the designs in a number of different mediums and sizes.

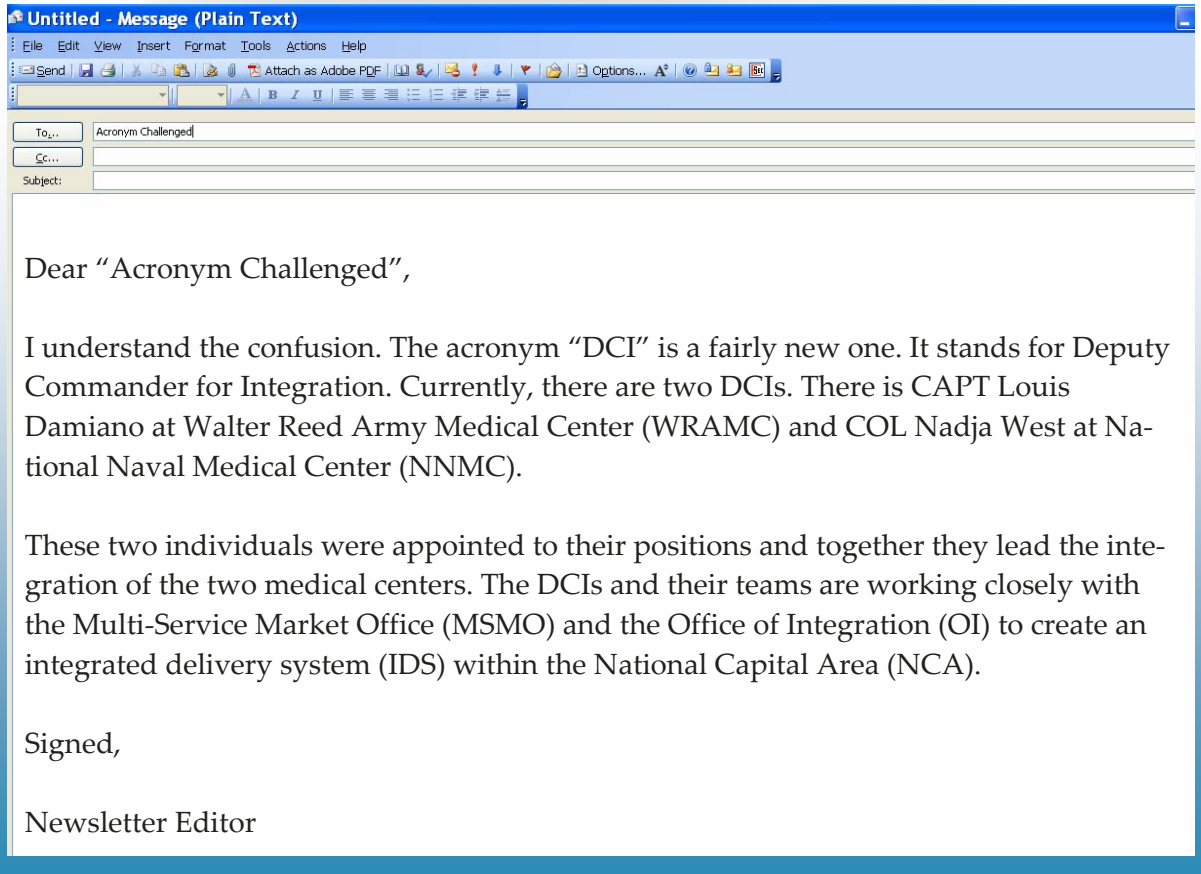
Generally, when an official military logo is finalized there is a "steward" assigned. This may be a person in the front office, a PAO, a Communications specialist or any similar entity who protects the use of the emblem, and sees that it is always used correctly, respectfully, legally and not in any derogatory manner.

In many cases a "Style Book" accompanies a newly designed official logo or emblem. A Style Book gives technical guidance as to how the logo can be reproduced and displayed. The "book" will clarify technical restrictions such as no alterations in design, in text, or in font. It will specify ink colors that must be used and usually dictates that nothing can intersect or touch the outside edge of the logo (such as an arrow, or other logos.) Often you'll see permission given to "ghost" or use the logo as a watermark, or guidelines to use the logo in black outline form or with certain size restrictions.

We are starting this process now so that we will be ready to launch a new WRNMMC emblem by the summer of 2008 and we will continue to keep you informed of our progress through this newsletter. ■

LETTER TO THE EDITOR





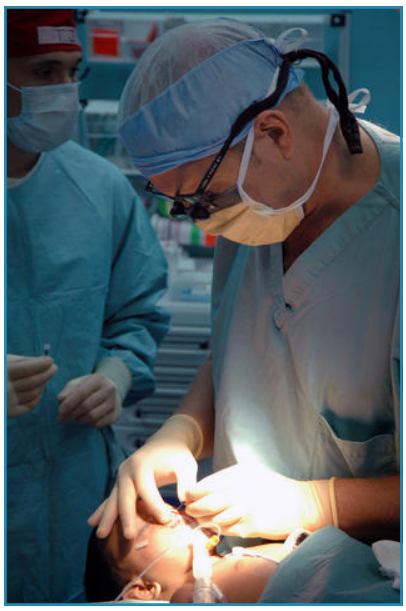
Dear "Acronym Challenged",

I understand the confusion. The acronym "DCI" is a fairly new one. It stands for Deputy Commander for Integration. Currently, there are two DCIs. There is CAPT Louis Damiano at Walter Reed Army Medical Center (WRAMC) and COL Nadja West at National Naval Medical Center (NNMC).

These two individuals were appointed to their positions and together they lead the integration of the two medical centers. The DCIs and their teams are working closely with the Multi-Service Market Office (MSMO) and the Office of Integration (OI) to create an integrated delivery system (IDS) within the National Capital Area (NCA).

Signed,

Newsletter Editor

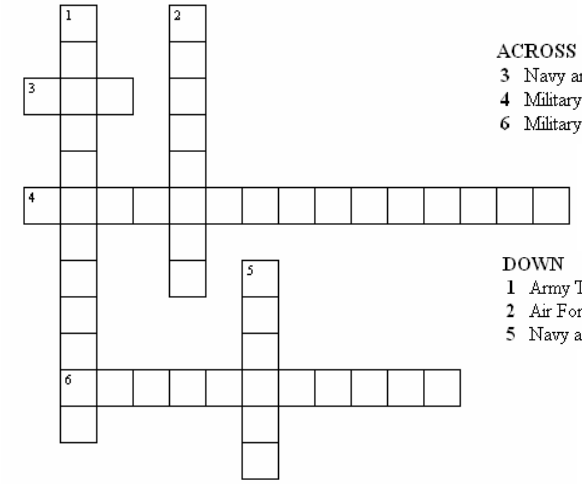


Our Mission:
Force Health Protection

To meet and adapt to the evolving health care needs of our military force, our mission, as established by the Department of Defense, is to use preventive health techniques and emerging technologies in environmental surveillance and combat medicine to protect all service members before, during, and after deployment.

Force Health Protection is designed to improve the health of service members, prepare them for deployment, prevent casualties, and promptly treat injuries or illnesses that do occur, as well as care for their family members, and retirees and their families, who have served this great nation.

TRI-SERVICE CROSSWORD PUZZLE



ACROSS
3 Navy and Marines Term: Acronym refers to large ships that are gray in color
4 Military Term: Describes all types of supplies
6 Military Term: NATO phonetic alphabet for "continue mission"

DOWN
1 Army Term: Describe the Army issued "large" ALICE pack
2 Air Force Term: Means "Watch out behind you"
5 Navy and Marines Term: Describes the new digital camouflaged field uniforms

ANSWERS FROM LAST MONTH:

ACROSS	DOWN
2 Bulkhead	**1 Triple Threat**
3 Hun	**2 Brass**
5 Beat Your Face	**4 Crank**
6 Gunny	

National Capital Area Military Health System

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THE FUTURE OF THE NCA

Our Vision

We envision and are committed to *one* integrated health system which leverages the assets of all DoD health care treatment facilities in the National Capital Area.

The Tri-Service Walter Reed National Military Medical Center at Bethesda will be a world-wide military referral center and together with the Uniformed Services University of the Health Sciences (USU), will represent the core of this integrated health system.

All Tri-Service facilities in the NCA and the USU will serve as a premier academic medical system focused on delivering the highest quality care, distinguished health professional education, and exemplary clinical and translational research.